arkansas health & wellness

2nd Quarter

Provider Webinar 2026

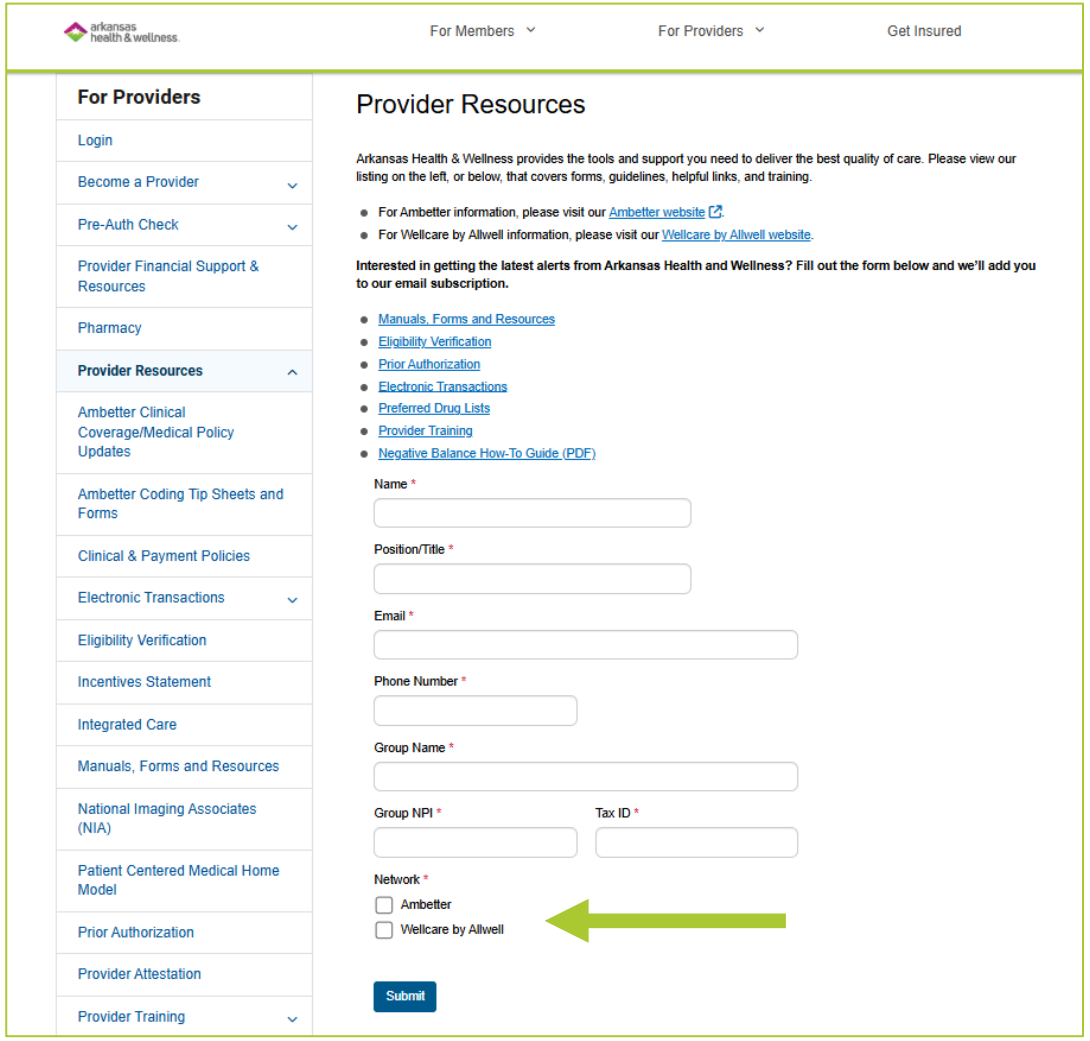
Disclaimer

- Arkansas Health & Wellness has produced this material as an informational reference for providers furnishing services in our contract network. Arkansas Health & Wellness employees, agents, and staff make no representation, warranty, or guarantee that this compilation of information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material.
- The presentation is a general summary that explains certain aspects of the program. It is not a legal document.
- Although every reasonable effort has been made to ensure the accuracy of the information within these pages at the time of publication, the program is constantly changing, and it is the responsibility of each provider to remain abreast of the program requirements. Any regulations, policies, and/or guidelines cited in this publication are subject to change without further notice.
-

Agenda

- Join Our Email List
- Clinical and Payment Policy Updates
- Coverage Changes for ARHOME
- Appointment Availability & Wait Times
- Prior Authorizations
- Secure Provider Portal
- Availity Essentials
- Sober Sidekick Program
- Transitional Care Management (TCM)
- Provider Self-Led Trainings
- Risk Adjustment
- Quality Improvement
- Key Contacts

Join Our Email List



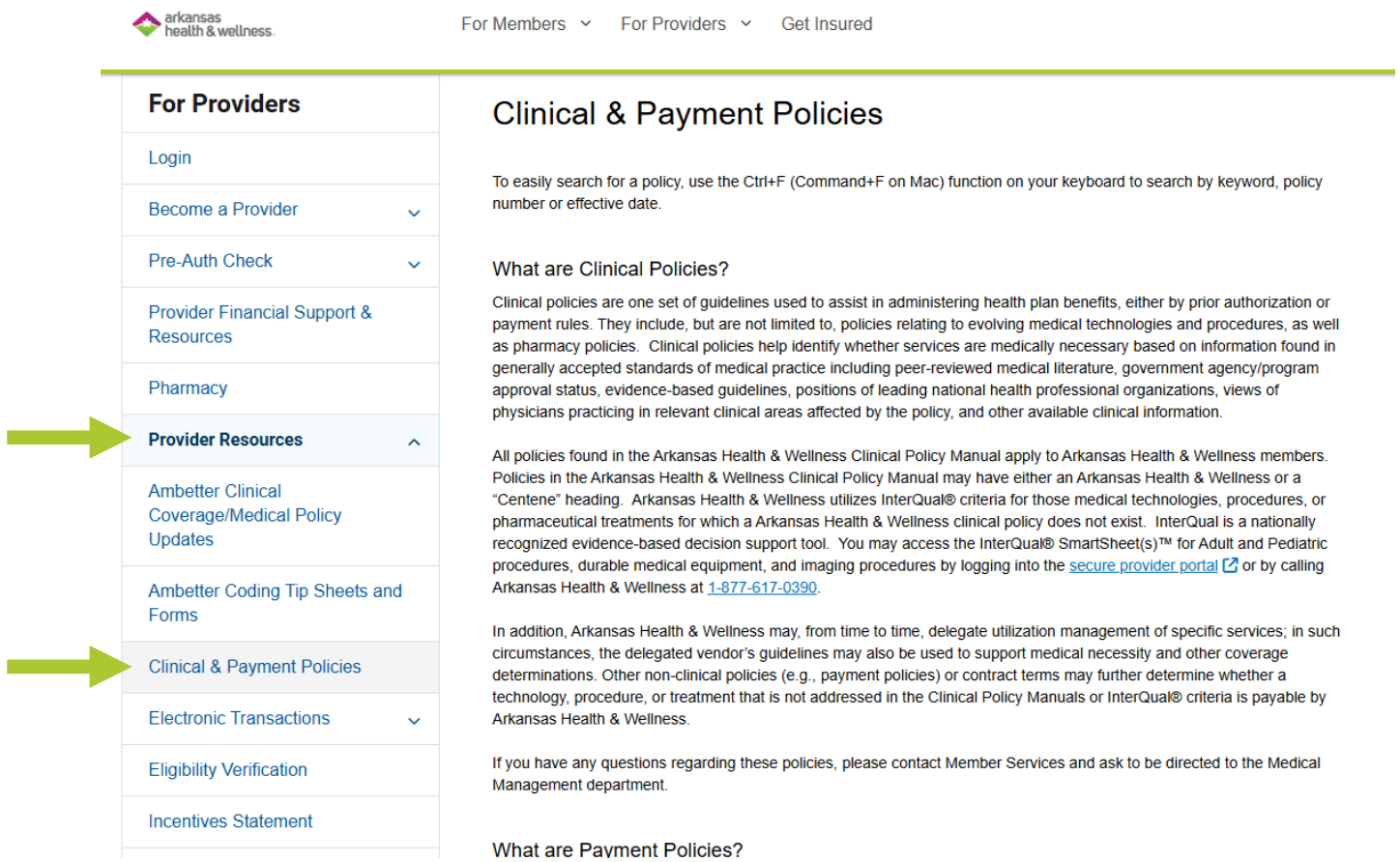
Receive current updates:

- **https://www.arhealthwellness.com/providers/resources.html**
- Choose the network you wish to receive information from: Ambetter or Wellcare by Allwell

Clinical and Payment Policy Updates

Clinical and Payment Policy Updates

Arkansas Health & Wellness routinely amends and/or implements new policies. These policies are available on our website at ARHealthWellness.com.



2026 Ambetter Other Insurance Coverage Changes for ARHOME

Coverage Changes for ARHOME

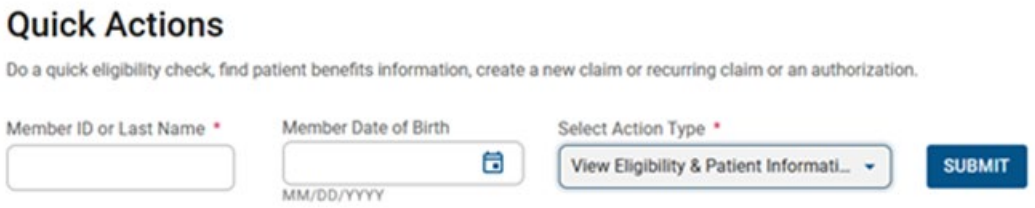
Effective January 1, 2026, Ambetter's ARHOME coverage is the payer of last resort for coordination of benefits purposes. This means that if members have any other insurance, it must pay first and Ambetter will pay claims as secondary.

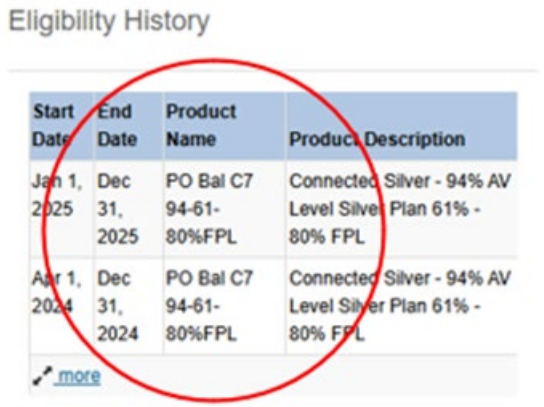
There are three main ways you can check to see if a member has an ARHOME plan.

Coverage Changes for ARHOME

1. Secure Provider Portal

Log in to your Ambetter Provider Portal at Provider.ARHealthWellness.com and use the Quick Actions tool to search for the appropriate member. If they have an ARHOME plan, the plan product name will start with a “PO Bal” identifier:

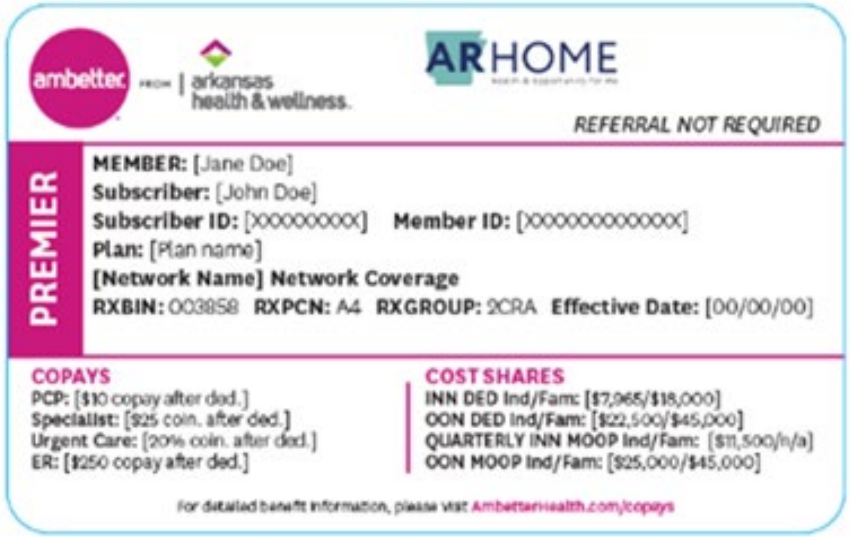




Coverage Changes for ARHOME

2. Member ID Card

Check the member's Ambetter ID card. If it has a blue ARHOME logo on the front, beside the Ambetter logo, that member is part of an ARHOME plan.



Coverage Changes for ARHOME

arkansas health & wellness

3. Call Center

Our call center is available to assist you in reviewing a member's plan division to determine whether they are an ARHOME member. Give us a call at 1-877-617-0390 (TTY: 1-877-617-0392).

What do I need to do?
For Ambetter members with ARHOME coverage, file claims with the primary insurance carrier first. You should file with Ambetter only after the claim has been filed with the primary carrier.

Appointment Availability & Wait Times

Appointment Availability & Wait Times

Ambetter follows the accessibility and appointment wait time requirements set forth by applicable regulatory and accrediting agencies. We monitor participating provider compliance with these standards at least annually and will use the results of appointment standards monitoring to ensure adequate appointment availability and access to care and to reduce inappropriate emergency room utilization.

Appointment Access Calendar

Appointment Type	Access Standard
PCPs – Routine Visits	15 business days
PCPs – Adult Sick Visit	48 hours
PCPs – Pediatric Sick Visit	48 hours
Behavioral Health – Non-Threatening Emergency	6 hours
Specialist Routine Visit	Within 30 business days
Urgent Care Providers	24 hours
Behavioral Health Urgent Care	48 hours
After Hours Care	Office number answered 24 hours/7 days a week by answering service or instructions on how to reach a physician.
Emergency Providers	24 hours a day, 7 days a week

Appointment Availability & Wait Times

Type of Care	Accessibility Standard*
Primary Care	
Emergency	Same day or within 24 hours of member's call
Urgent care	Within 2 days of request
Routine	Within 21 days of request
Specialty Referral	
Emergency	Within 24 hours of referral
Urgent care	Within 3 days of referral
Routine	Within 45 days of referral

The in-office wait time is less than 45 minutes, except when the provider is unavailable due to an emergency.

Type of Care	Accessibility Standard*
Maternity	
1st trimester	Within 14 days of request
2nd trimester	Within 7 days of request
3rd trimester	Within 3 days of request
High-risk pregnancies	Within 3 days of identification or immediately if an emergency exists
Dental	
Emergency	Within 24 hours of request
Urgent care	Within 3 days of request
Routine	Within 45 days of request

Prior Authorizations

Prior Authorizations

- Arkansas Health & Wellness requires prior authorization as a condition of payment for many services. This notice contains information regarding such requirements and is applicable to all Marketplace products offered by Ambetter.

- We are committed to delivering cost-effective, quality care to our members. As such, we want to make sure our members receive only treatments that have been deemed medically necessary by current standards of practice. Prior authorization allows us to verify the medical necessity of a treatment in advance, using independent, objective medical criteria and/or in-network utilization where applicable.

- The prior authorization process is initiated by the physician, and it is the ordering/prescribing provider's responsibility to determine which codes require prior authorization. Please verify eligibility and benefits prior to rendering services to patients. Payment, regardless of authorization, is contingent on the member's eligibility at the time the service is rendered. Nonparticipating providers and facilities require authorization for all services except where otherwise indicated.

How to Secure Prior Authorization

Prior Authorizations can be requested in the following ways

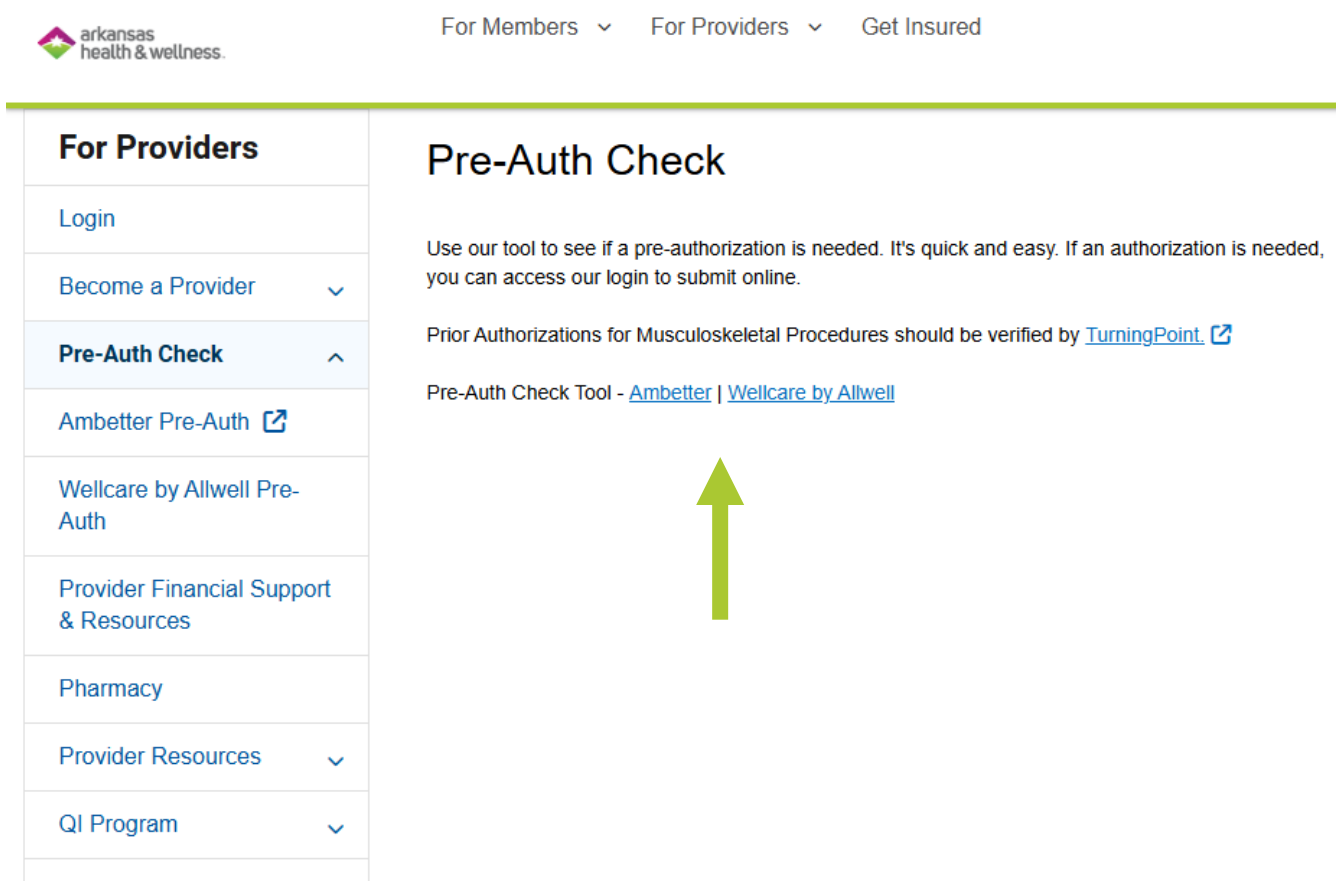
- **Secure Web Portal:** This is the preferred and fastest method
  - Ambetter and Wellcare by Allwell: **Provider.ARHealthWellness.com**

- **Phone**
  - Ambetter: 1-877-617-0390
  - Wellcare by Allwell: 1-855-565-9518

- **Fax**: IP and OP forms are available on the **Provider Resources** page
  - Ambetter: 1-866-884-9580
  - Wellcare by Allwell: 1-833-562-7172

After normal business hours and on holidays, calls are directed to the plan's 24-hour Nurse Advice Line. Notification of authorization will be returned via phone, fax, or web.

Pre-Auth Check Tool

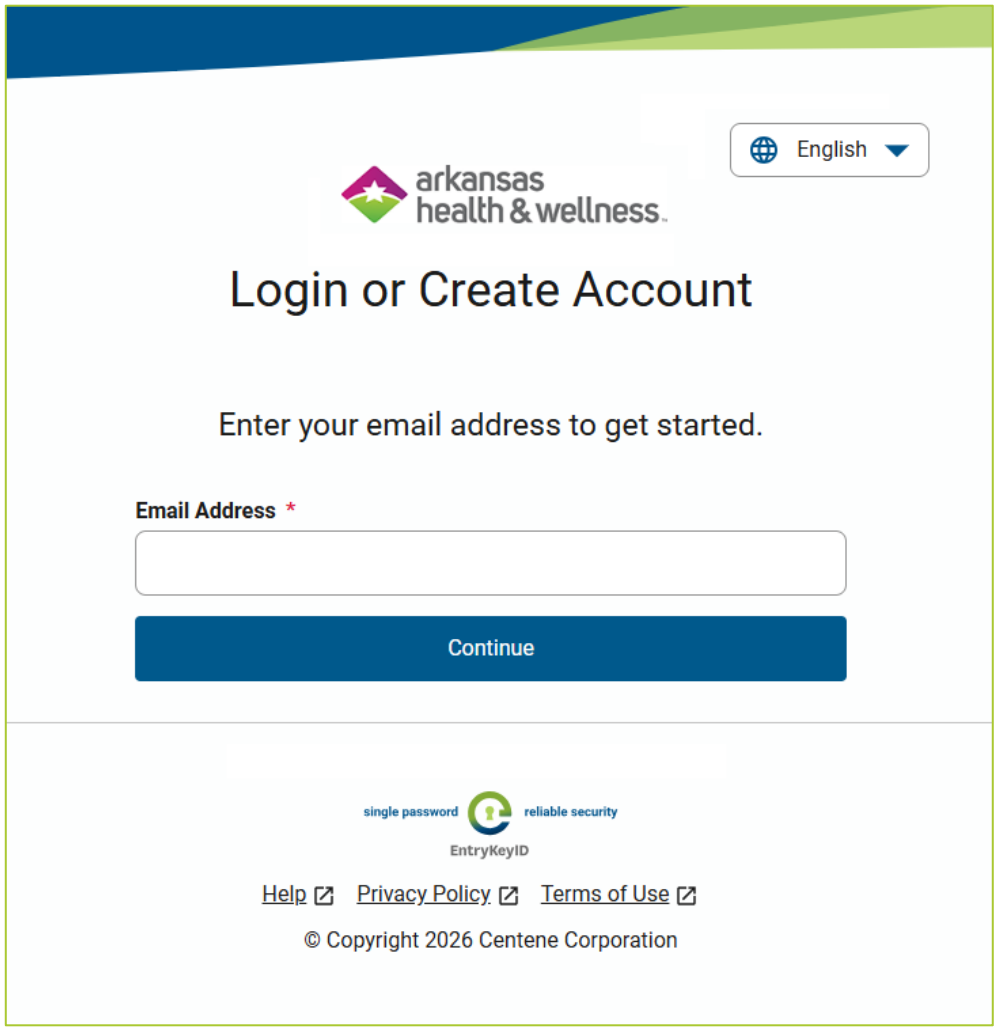


We offer an online **Pre-Auth Check tool** to make verifying prior authorization requirements as easy as possible.

Simply open the tool, choose between Ambetter and Wellcare by Allwell, and follow the prompts.

Secure Provider Portal

Secure Provider Portal – Create An Account



Visit Provider.ARHealthWellness.com, enter your provider email, and select Continue. From there, you will be prompted to register for an account.

Provider Portal Features

- Member eligibility overview page that reflects all critical data in a single view
- Ability to submit and track the status of claim reconsiderations online
- Expanded free text fields for reconsideration comments and explanations
- Ability to attach required documentation when filing a reconsideration
- Ability to upload records for care gap information
- Option to receive push notifications regarding reconsideration status changes
- Void/recoup option on claims already adjudicated by the health plan

Availity Essentials

Availity Essentials

- Effective since November of 2024, providers can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access Arkansas Health & Wellness payer resources through Availity Essentials.
- If you are already working in Essentials, you can log in to your existing Essentials account to enjoy these benefits.
- Use Availity Essentials to verify member eligibility and benefits, submit claims, check claim status, submit authorizations, and more.
- Access Manage My Organization — save provider information in Essentials and auto-populate it to save time and prevent errors.
- Look for additional functionality in Arkansas Health & Wellness' payer space on Essentials and use the heart icon to add apps to My Favorites in the top navigation bar. Our current Secure Provider Portal will still be available for other functions you may use now.

If you are new to Availity Essentials, getting your Essentials account is the first step toward working with Arkansas Health & Wellness on Availity.

Availity Designation

Getting Started: Designate an Availity Administrator for Your Provider Organization

Your provider organization’s designated Availity administrator is the person responsible for registering your organization in Essentials and managing user accounts. This person should have legal authority to sign agreements for your organization.

Sober Sidekick Program

Sober Sidekick Program

Sober Sidekick is a virtual platform designed to empower addiction by connecting individuals with tools and resources in their communities. This includes creating opportunities for connection, encouragement, and shared experiences through its peer-driven community.

By gathering and analyzing behavioral insights, the partnership will enable a deeper understanding of challenges and opportunities, allowing for more proactive and supportive care for those in recovery.

- **Bridging gaps in care**
- **Reducing relapse rates**
- **Scalable recovery support**
- **Available to all Arkansans**

This resource is available to all Arkansas residents in partnership with Ambetter from Arkansas Health & Wellness.

Transitional Care Management (TCM)

Transitional Care Management (TCM)

- The TCM program is a new initiative by Arkansas Health & Wellness aimed at improving the care coordination and outcomes for high-risk behavioral health members with high-risk substance use disorders receiving inpatient treatment. By providing targeted support before discharge, we aim to reduce readmission rates and enhance the overall quality of care.

- The TCM team is here to assist members in coordinating medical, behavioral, and social needs prior to discharging and upon entry into the community. The team's goal is to ensure the members are equipped with appropriate resources and support to facilitate an easy transition from your facility

How TCM Program Works

1. Identification
Care managers will identify high-risk behavioral health members who are receiving inpatient treatment.

2. Assessment
A thorough assessment will be conducted to understand the members needs and develop a care plan.

3. Coordination
The care manager will work closely with the member, facility, staff, and other providers to coordinate care and ensure a smooth transition.

4. Follow-Up
After discharge, the care manager will continue to follow up with the member to monitor progress and address any issues that arise.

The TCM team will contact the treating provider to coordinate a meeting with the member while the member is still receiving inpatient care. This interaction is intended to support both the provider and the member. Some of the support provided can include assistance with discharge planning, coordinating resources, addressing social determinants of health (SDoH), and care gaps. The goal is to ensure all discharge needs are addressed prior to returning to their community setting

Key Benefits of TCM

- **Improved Member Outcomes:**
  Coordinated care before discharge means more comprehensive support, leading to better health outcomes
- **Reduced Readmission Rates:**
  Aims to reduce the likelihood of members being readmitted to the hospital by ensuring they have the necessary resources and follow-up care
- **Enhanced Care Coordination:**
  Facilitates better communication between care providers, ensuring that all aspects of the members care are addressed
- **Member Empowerment:**
  Empowers members to take an active role in their care by providing them with the resources and support they need
- **Provider Collaboration:**
  By engaging providers in a coordinated care approach, the program ensures that all stakeholders are informed and aligned on the members care plan.

To learn more, contact us at 1-800-575-2763 or email Provider Relations at Providers@ARHealthWellness.com

Provider Self-Led Trainings

Provider Self-Led Trainings

Arkansas Health & Wellness offers several self-led provider trainings. These annual trainings are available 24/7 on the Provider Training Page. After completion of the training, providers should fill out and submit an Attestation Form.

Risk Adjustment

Risk Adjustment Overview

Risk adjustment is a tool used to predict the likely use and cost of healthcare based on an individual's risk factors, including:

- Age
- Gender
- Community Status
- Severity of health conditions

RAF Score						
Age	+	Gender	+	Disease Conditions	+	Reason for Entitlement

Importance of Risk Adjustment

Health Status

Identifies the actual disease burden of member populations and captures changes in patient's condition status or severity

Quality of Care

Improves chronic condition monitoring and management through earlier identification of care gaps and proactive care planning

Appropriate Funding

Ensures accuracy of healthcare premiums and coverage of expenditures incurred by members with varying health needs.

Hierarchical Condition Categories (HCC)

- HCCs reflect hierarchies among related disease categories.
  - Only the most severe HCC within a hierarchy is calculated in the RAF score.
  - HCCs captured from unrelated diagnoses are cumulative.
- HCCs must be captured annually
  - Reporting period is Jan 1–Dec 31

- CMS determines the qualifying ICD-10 diagnosis codes for each category and assigns the risk factor value.
  - Not all diagnoses map to an HCC.
  - Some diagnoses map to multiple HCCs.

Medical Record Requirements

- Face-to-face encounter
- Acceptable provider type
- Acceptable service type
- Correct entry for date of service
- Two patient identifiers
- Use of standard abbreviations
- Complete and legible
- Proper signature w/ credentials

MEAT Documentation

M Monitor	Document signs, symptoms, disease progression, and ongoing surveillance of the chronic condition.
E Evaluate	Document current state of chronic condition, physical exam findings, test results, medication effectiveness, and response to treatment.
A Assess	Document discussion of chronic condition, review of records, counseling, how chronic conditions will be managed, and the need for further tests.
T Treat	Document care being offered for chronic condition(s), prescribing or continuing of medications, referring to specialists, ordering diagnostic studies, therapeutic services (therapies), other modalities, and planning for management of chronic condition(s).

Risk Adjustment Program Goals

We are committed to helping our provider partners:

- **Understand risk adjustment concepts**
- **Apply best practices to workflow**
- **Increase HCC coding proficiency**
- **Improve quality of care provided**

Risk Adjustment Program Initiatives

Continuity of Care (CoC)	Provider incentive program — increases visibility into members' existing medical conditions for chronic condition management (PCP only).
In-Office Assessment (IOA)	Provider incentive program — supports early detection and ongoing annual assessment of chronic conditions for patients to help improve health outcomes.
Clinical Documentation Improvement (CDI)	Complimentary review of provider coding and documentation trends with education tailored to review findings.
Annual Chart Review Projects	Vendor works with providers and health plan to retrieve medical records and accurately report members health status in compliance with Risk Adjustment guidelines.

2026 Continuity of Care Plus (CoC+)

1 Risk Adjustment Insight

Eligibility Requirements

Participating PCPs can earn up to $300 per member. Provider within assigned TIN must:

- Complete a qualified visit with member during the program year (January–December)
- Prospectively address patient conditions at the point of care utilizing appointment agenda
- Include ICD-10 code(s) for all active conditions (supported in the medical record) on claim for DOS
- Submit completed agenda with 100% of conditions assessed

2 Comprehensive Insights

Additional incentive opportunity:

$150	per Medicare Agenda
$100	per Marketplace Agenda

All boxes related to the high complexity, quality, clinical, and/or drivers of health insights must be checked and verified, where applicable.

2026 CoC+ Program runs through December 31

2026 CoC+ New & Improved Features

arkansas health & wellness

Centene Clinical Action (CCA) Portal

- Access the 2026 CoC+ Program dashboard from the CCA Portal
- Electronically submit completed appointment agendas in CCA Portal
- Easily access from Availity, Arkansas Health & Wellness, and Wellcare portals with Single Sign-On (SSO) option.

PDF Appointment Agenda

- New table-style format for streamlined display of available insights
- Additional checkbox response options added for more defined insight assessment selection

New Fax Number for Paper Agenda Submissions

- Fax: 844-608-0465
- Exclusively for CoC+ Appointment Agendas (no medical records or other document types, please)

Medical Record Requests

- Members diagnostic data submitted by the health plan for risk adjustment purposes is subject to annual review. There must be documented evidence supporting every diagnosis reported through claims.
- To ensure ICD-10-CM codes obtained from claims submissions are accurate and conform to applicable risk adjustment regulation, annual medical record retrieval and review is required.
- Prompt compliance and cooperation in providing medical records requested through our HIPAA contracted business partners or to the health plan directly is important to business operations.

Risk Adjustment & Behavioral Health Providers

arkansas health & wellness

Medical record requests may include:

- **Progress notes:** Documentation should include session start and stop time, treatment type and frequency, diagnosis, treatment plan, symptoms, prognosis, and patient progress.
- **Mental Health Assessment:** Documentation should include client name, gender, date of birth, the current status of all mental and/or behavioral health diagnoses, and dates of service.

Private psychotherapy notes should remain separate from the patient's chart and are not part of the medical record request for risk adjustment purposes. (45 CFR 164.501)

All documentation (e.g., progress notes, treatment summaries, etc.) must be legible and signed by the provider rendering the services and include provider's credentials.

Risk Adjustment Data Validation (RADV) Policy Updates

CMS has implemented policy changes for RADV

- Annual audits for all Marketplace and Medicare Advantage plans
- Expanded record samples
- Accelerated audit timelines

Due to CMS's aggressive work plan, providers may experience:

- Higher volume of record requests
- Tighter turnaround windows

EMR Integration

Benefits of automated data exchange between payor and provider:

- Increased data accuracy
- Improved workflow
- Decreased administrative burden
- Enhanced patient care
- Better health outcomes

Bi-directional feed and point of care alerts can be integrated into EMR:

Athena	Epic	eClinical Works
Allscripts	Practice Fusion	Cerner
Office Ally	NextGen*	Meditech*

*Future Connections

Summary of Best Practices

arkansas health & wellness

- Comply with medical record requests in a timely manner
- Utilize program data and integrate into workflow
- Assess ALL active conditions annually
- Be clear and consistent in medical record
- Build rapport with RA specialists to close care gaps
- Follow timely filing rules for claim submissions
- Code to the highest specificity
- Include ICD-10 code on claim

Clinical Documentation Improvement Webinars

arkansas health & wellness

Risk Adjustment Coding and Documentation Education

Join our CDI Webinar Series designed to enhance your understanding of:

- Risk Adjustment methodologies
- Accurate and compliant documentation practices
- Coding strategies aligned with regulatory standards

Who Should Attend?

Providers, non-physician practitioners, coders, billers, and administrative staff involved in clinical documentation and coding.

> Advanced registration is required. Utilize the corresponding registration link provided for each topic (links are unique to each webinar). If you have questions or need assistance with registration, email **CDIWebinars@centene.com**.

2026 Webinar Series

Registration Link: January–November

Register here!

Resources

Contacts

- Send secure email to RiskAdjustment@ARHealthWellness.com or contact your assigned Risk Adjustment Specialist.

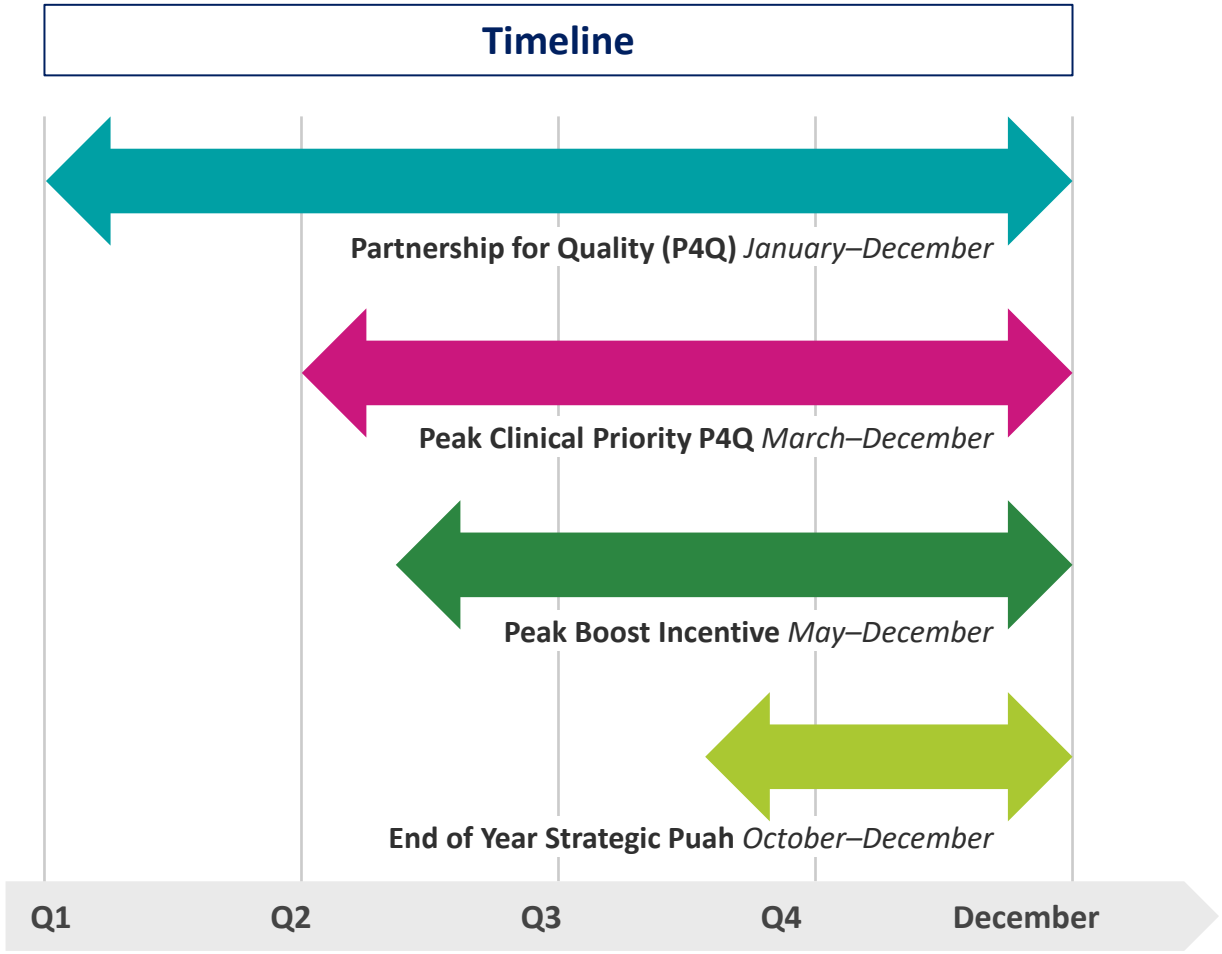
Risk Adjustment Coding & Documentation

Coding documentation guidance for healthcare providers, coders, and support staff are available on our website following the URLs listed below.

- Wellcare by Allwell:
  https://www.arhealthwellness.com/providers/resources/Allwell_CODING_TIP_SHEETS_AND_FORMS.html
- Ambetter from Arkansas Health & Wellness:
  https://www.arhealthwellness.com/providers/resources/Ambetter_CODING_TIP_SHEETS_AND_FORMS.html

Quality Improvement

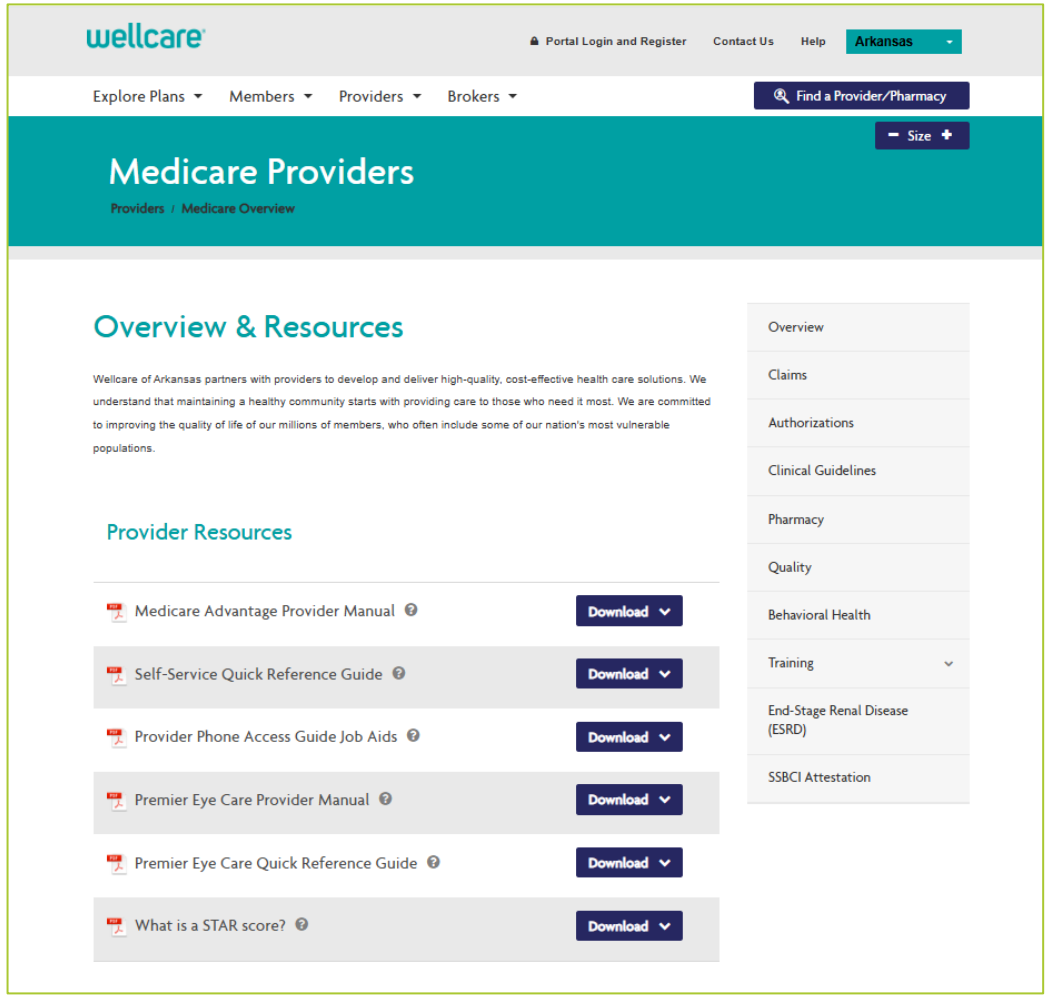
2026 Wellcare Partnership for Quality (P4Q) Program



- Wellcare provider incentive program
- PCPs can earn additional compensation by addressing preventive care activities and closing care gaps for members
- Earn even more by caring for Clinical Priority members
- Clinical Priority patients may require a greater level of care due to chronic illnesses, disabilities, age, or other factors that necessitate the need for more frequent provider visits, specialized treatments, and chronic care support.

Arkansas Medicare Provider Resources

Access Medicare provider materials, including the Arkansas Medicare Quick Reference Guide, at Wellcare.com/Arkansas/Providers/Medicare.



2026 Ambetter Pay for Performance (P4P) Program

- Enhance quality of care through a PCP-driven pay-for-performance program with a focus on preventive and screening services
- Members who have been formally assigned to a provider's TIN
- Selected measures are focused on PCP engagement, screening services, and medication adherence
- Each measure has its own incentive amount, paid after achieving its own target score
- Three payouts per year: Q2, Q3, Q4
- Monthly reporting gaps in care
- Monthly performance scorecards

CPT II Coding and HCPCS Billing for Medicare Advantage Plans

arkansas health & wellness

Submitting CPT II and HCPCS codes improve efficiencies in closing patient care gaps and in data collection for performance measurement. Wellcare has taken steps to help ensure submissions for select codes to the Medicare fee schedule at a price of $0.01.

Medicare Annual Preventive Visit Discussion Points

- Update patient's medical record, including demographics, other treating providers, and family history
- Conduct SDoH assessment
- Discuss advanced care planning
- Screen for cognitive impairment, including depression, mental health, and emotional wellbeing
- Conduct a medication reconciliation and extend day fill opportunities (mail order or 90 days at retail)
- Complete pain and functional assessments, including DME use
- Assess bladder leakage and care options
- Create a preventive screening schedule and refer members for tests, imaging, counseling, and care programs
- Complete the health risk assessment
- Create a list of patient balance/fall risk factors and conditions
- Check routine measurements
- Review current opioid prescription and screen for potential substance use disorders

Key Contacts

Provider Services Call Center

First line of communication

- Ambetter:
  1-877-617-0390 (TTY: 1-877-617-0392)
- Wellcare by Allwell:
  1-855-565-9518 (TTY: 711)

Representatives are available Monday through Friday from 8 a.m. to 5 p.m. CT

Provider Service Representatives can assist with questions regarding:

- Member Eligibility
- Claim Inquiries
- Prior Authorization
- Network Verification
- Appeal Status
- Payment Inquiries
- Check Stop Pay or Check Reissues
- Negative Balance Report
- Provider Demographic Change Request
- Secure Portal Password Reset

Provider Inquiries

- After speaking with a Provider Service Representative, you will receive a reference number, which will be used to track the status of your inquiry.
- If you need to contact your assigned Provider Relations Representative, you must have the following when submitting an email inquiry:
  - Reference number assigned by the Provider Services Center
  - Provider Name
  - Tax ID
  - National Provider Identifier (NPI)
  - Summary of the issue
  - Claim numbers (if applicable)

Providers@ARHealthWellness.com

Contracting and Credentialing

Contracting Department

- ArkansasContracting@centene.com

  Regular contracting inquiries and contract requests

Credentialing Department

- ArkCredentialing@centene.com

Education Requests

Would you like training for you and your staff?

You can submit your requests to:
Providers@ARHealthWellness.com